During the reporting period a total of 89,841 patients attended the general O.P.D. and received treatment for their illnesses. The visits comprised 17% men, 34% women, 25% children under 4 years of age and 24% children between the age of 5 and 14 years.

About 77% of the total patients were treated against six common diseases i.e. Respiratory Tract Infections (22%), Gastric Problems (20%), Skin Infections (12%), Fever of Unknown Origin (PUO) (10%), Psychosomatic Illnesses (7%) and Obstetric problems (6%).

To support the medical officers in their diagnosis and treatment, field laboratories have also been established at Ghazi and Haripur camps where various specimens are examined by skilled Laboratory Technicians.

A total of 15107 specimens were examined by these field laboratories at the request of the BHU medical officers and of these, 2136 specimens were found to be positive or abnormal.

Out of the total specimens examined, 88% were blood samples, 6% were sputum samples, 4% were urine samples, 1.50% were stool samples and .50% samples were for a pregnancy test.

7. <u>T.B CONTROL PROGRAMME</u>

This is one of the most important programmes being implemented in the camps. T.B is a very common disease among the refugee population and it has taken a lot of effort to prevent it from spreading. There are still many T.B patients in the camps, but the situation is not as alarming as it was in the earlier days of the refugee programme.

Due to the prevalence of this disease, special T.B clinics are held in every B.H.U. on a fortnightly basis. During these clinics the registered T.B patients are examined by the medical officer and treatment is given to them. Similarly the suspected T.B patients are referred for X-rays and sputum examination and if found positive or suggestive, they are given anti-T.B treatment.

During the reporting period 98.50% of the 69 registered T.B patients were receiving their anti-tuberculous treatment on a regular basis.

A total of 40 T.B patients completed their full course of treatment and 46 new T.B patients were registered in the T.B clinics and commenced anti T.B treatment after investigations.

Close family members of the positive T.B patients were also screened regularly to find out whether they have been afflicted by the disease or not.

Efforts are also made to ensure that all the registered T.B patients come and receive their respective medicines on a regular basis. If in some cases the patients are not regular and default in their treatment and do not come to the BHU on the specified dates, they are located with the help of CHSs and CHWs who, after motivation, bring them to the BHUs to continue the treatment.

The patients are also educated about the preventive measures necessary to check the spread of this disease among the family and the community.

In some cases, specialised consultation is also provided by the I.C.D. (Italian Co-operation for Development, an Italian agency implementing the T.B control program for Afghan Refugees). I.C.D is also providing technical and material support, in the shape of Mobile X-ray units, training of laboratory personnel, supply of anti-T.B. medicines and laboratory reagents for sputum examination etc.

8. MALARIA CONTROL PROGRAMME

Every year worldwide 100 million malaria cases cause hundreds of thousands of child deaths and many more cases of child malnutrition. It also causes deaths and other complications in the adult patients.(Facts for Life)

Malaria is one of the most common diseases among the refugee population. To control this disease, a Malaria Supervisor has been attached to each B.H.U, whose responsibility it is to take blood samples from the suspected cases and provide them with a complete treatment regime, if found positive after the laboratory examination. The suspected cases are also provided with radical treatment.

The malaria supervisors collected a total of 12,829 slides for the investigation of malaria and of these 1544 or 12% were found positive. All these malaria positive cases were able to receive full anti malarial treatment.

The malaria supervisors also collect blood samples for mass screening of the population especially when any case of Plasmodium Falciparum malaria is detected. As a routine the Malaria Supervisor collects blood samples from twenty families residing in the area where the Falciparum case is detected.

The reason for this is that this type of malaria is very dangerous and if not detected and treated in time, may cause death. During this period a total of 134 patients have been detected who were suffering from Plasmodium Falciparum Malaria.

To control the spread of disease and especially the breeding of mosquitoes, the office of the Deputy Project Director Health (GOP/UNHCR) for Malaria Control supplies malaria insecticide for spraying, in the camps, once a year. Malaria supervisors with the help of male outreach health workers carry out this malaria spray campaign in the camps.

It is interesting to note that during the current period no such spray campaign has been undertaken as no insecticide was given to the project by the GOP/UNHCR. The reason for this non-supply is that some resistance to Malathion, the insectical drug, has been reported. It is important to note that the project has noticed, and reported to the GOP/UNHCR, that malaria and particularly PF is increasing. This seems to be mainly due to the lack of the Malathion spray campaign during 1990.

The camp people are also educated by the Sanitarians, Malaria Supervisors, CHSs and CHWs to keep their surroundings clean and fill in the ditches and other water ponds in the camps which contain stagnant water, so as to decrease the breeding grounds for mosquitoes.

During the concluded period, the outreach workers managed to close 84 water ditches in different parts of the camp.

9. MINOR SURGERY

In order to deal with minor injuries, wounds and burns etc., three nursing assistants have been attached to the curative team. These nursing assistants work alternate day in each BHU on male days, and on female days one of the female staff from the BHU attends the patients.

The patients are usually referred by the outreach workers i.e. CHSs and CHWs. Nursing assistants dress the wounds, burns and skin infections under the guidance of the medical officer. The injections to T.B and other general patients and intravenous therapy to emergency patients is also given under the supervision of medical officer.

During the current reporting period the nursing assistants gave 7314 injections, dressed 9511 wounds, dressed and treated 519 burn cases, drained 364 abscesses through incisions, stitched a total of 43 wounds, conducted 28 circumcisions and washed the ears of 6 persons.

10. REFERRAL OF PATIENTS / EMERGENCY MEDICAL COVER

The medical officers conducting the general O.P.D.s also refer patients who may need hospitalization or any specialized treatment not available in the BHUs different Government hospitals at Peshawar and Abbottabad, Similarly, emergencies are also referred to these hospitals and in most of the cases transportation facilities are also provided by the project.

The medical officers referred a total of 650 patients to government hospitals for investigation and or specialized treatment from Ghazi and Haripur camps.

To deal with other emergencies which do not need hospitalization, medical and para medical staff remain on emergency duty after the duty timings in Ghazi camps only. The reason for this being that in Ghazi there is no other facility available to the refugees outside their camp and also the field office at Ghazi is very close to the refugee camps as compared to Haripur where the field office is about 15 k.ms away from the nearest camp. The refugees in Haripur usually take their emergencies to the government civil hospital or to the private hospitals in Haripur town.

During the current reporting period emergency medical cover was provided to a total 1883 patients.

11. CAMP SANITATION

The members of the male outreach health workers team i.e. the Sanitarian and Community Health Supervisors are also responsible for the environmental or camp sanitation.

Their main role is to create awareness among the people about sanitation and also to assist them in the construction of proper pit and surface latrines and places for the safe disposal of the waste in the camps. This team also educate the people about the proper maintenance and use of these latrines.

During the concluded period, while checking on the camp sanitation, a total of 5786 pit and surface latrines have been inspected every month by the outreach workers.

Another important task of the same team is to advise the people living in the camps about the proper use of water from the lake, river and wells.

The use of contaminated water by the refugees has created many health problems, especially the Gastro intestinal diseases. This sanitation team advises refugees to use clean water for drinking and cooking purposes. The same team is also responsible for the inspection and upkeep of water sources in the camps.

These outreach workers inspected a total of 166 water tanks, 69 water taps and 474 wells in the camps once a month and advised people about proper drainage of water. This team also managed to chlorinate all the wells once every three months.

Yet another role of this team is to visit the shops in the camps selling edible food and give advice to the shopkeepers to protect their merchandise from flies and dust and always sell fresh and clean food items. In this regard a total of 1191 visits have been made to general food and butchers shops during the reporting period.

Rabid dogs in the camps are a threat to the lives of the people and in some cases people have died from rabies. The health workers always instruct the people to kill the rabid dogs and keep their pet dogs inside their houses.

During the same period the health workers killed two rabid dogs, with the help of refugees.

12. MOTIVATION OF DEFAULTERS

The male outreach workers team also assist the BHU staff in implementing and carrying out some of their programmes by locating and motivating defaulters who are registered in different clinics (e.g. T.B, Malaria, Ante - Natal, Under two and E.P.I) but fail to come on a regular basis as required by the schedule of that clinic, which makes their treatment irregular and therefore less effective.

All these defaulters are located on the instructions of the BHU medical officer and concerned BHU staff and are convinced to complete their full course of treatment or immunisation as the case may be. This helps to ensure that the patient is fully cured and does not cause problems for other people. All these defaulters are followed up on a regular basis.

During the current period 12 T.B. defaulters, 390 Under-2 clinic defaulters, 365 Malaria cases, 1259 under-2 children for vaccination have been located, motivated and or referred to the BHUs.

13. ASSISTANCE

These outreach workers teams are of great help and assistance to BHU staff in implementing their programmes because they provide assistance and support to their BHU colleagues who, from time to time, undertake some special task or programmes like mass immunisation programmes for women and children, malaria spray campaign in the camps, carrying out different surveys, chlorination of water wells and location of disabled people in the camps etc. They also assist in spreading different messages from the BHUs among the camp people.

14. BIRTHS AND DEATHS RECORD

Another important task being undertaken by these teams is the collection of monthly figures on births and deaths in the camps and if possible, the causes of deaths are also recorded. This record help the medical teams to cross-check the births and deaths with their own records and also helps them in issuing a birth certificate for the new born child and registering him/her for future care.

N.B * **Readers are advised that all the medical statistics and the figures given in the above report have been taken from the consolidated statistics for Ghazi and Haripur camps. For interested persons these statistics are attached at the end of this report.**

SECTION III

ADMINISTRATION AND FINANCE

ADMINISTRATION

As mentioned earlier, Peshawar office is responsible for the overall administration of the project. It is also providing administrative and logistics support to the field offices which include formulation of policies, supply of stationery, medicines and all other programme related materials being used in the camps.

The Peshawar office is also acting as a liaison between the camps and UN, Government of Pakistan Afghan Refugee Commissionerate, Project Director Health and other voluntary agencies and keeps them informed of all the developments being made in the Afghan Refugee medical programme.

All the progress and financial reports on the programmes are prepared and sent to the respective donors on a regular basis.

Monthly Project Management Meetings between the Director and all the Programme Officers, Manager Administration and Project Accountant were held in Peshawar and a number of matters pertaining to the development of the project were discussed. Additional planning meetings were also held between the Director and the concerned officer to discuss some specific matters.

Once every three months the Territorial Commander chaired a Quarterly Board Meeting in Peshawar comprising Financial Secretary, Project Director and the Project Management. Here he is updated on the activities of the previous quarter by all project management and plans are made and discussed for the following three months. The same Board makes major policy decisions regarding the future of the programme.

The project management is placing more emphasis on the training of staff at different levels so that their abilities can fully be utilized by the project. In doing so the project initiated a training programme in which the BHU para-medical staff and members of the outreach workers team were given additional training in E.P.I vaccination, Malaria and Dressing of wounds etc. This training was imparted by the Programme Officers medical services at Ghazi and Haripur and a total of 39 persons received this training.

Also the project management and mid level management, including the medical officers were also exposed to a number of management courses at Pakistan Institute of Management in order to make them more conversant with modern management techniques. This make them more capable for their own future and also assists them in running the programme in a better way.

Some administrative changes which have been brought during the previous project, continued during the reporting period. The first step taken previously in this regard was the elevation of Administrative Assistants to Assistant to Programme Officers giving them some more responsibilities. The next step taken was making the BHU medical officers more independent in their day to day work and making them fully responsible for all the BHU activities. Now the medical officers have been given more authority which they never enjoyed before.

Also mentioned in the previous report was the preparation of the pay scales for the project staff. Now these pay scales have been agreed and implemented during the current project.

Another achievement by the administration was to computerize all the personnel records of the project staff, which in future will help in the preparation of budgets etc.

The administration took another step for the welfare of the project staff and insured all of them against accidental death or injury for one year.

The Manager Administration in consultation with project management and the Director introduced a new policy regarding the retirement of staff members.

The Director in consultation with project management also introduced separate work agreements for the project management, which were agreed to and accepted by the Territorial Commander.

FINANCIAL NARRATIVE

As already mentioned, sincere thanks are extended to the U.S. State Department Bureau for Refugee Programmes for their continued funding of this project.

Also mentioned in our previous report, a new project accountant has taken over all the finances of the project and it is worth mentioning that due to his dedicated work and able assistance from his assistant, all the procedures have now been streamlined.

The Finance department is now better able to serve the field with analysis of financial information as well as the normal donor reporting requirements.

It is worth mentioning that during the current project all the project expenditures were audited by the external auditors and all the finances were found in order. Also, the accounts department were able to produce, for the first time since the inception of the Afghan Refugees Assistance Project, an Income and Expenditure Account and Balance Sheet for every donor. Now this will be regularly produced at the end of the project financial year.

Attached in Annex 13 is the Income and Expenditure Accounts and Balance Sheets for projects PD - 734 (II) and PD - 734 (III). These Balance Sheets show two loans taken by Vocational and Leather Work Income projects from PD - 734 (III). These loans were given to assist in internal cash flow problems and have been repaid at the time of writing this report.

The Project Expenditure Board constituted previously with the Director as Chairman and the Project Accountant and Manager Administration as its members, continued to function on a weekly basis, monitoring and streamlining all the project expenses in line with the designated budget categories.

Monthly financial analysis reports are also being produced every month, for all the projects, by the finance department which assists the project management in monitoring their monthly expenses according to budget line items.

Attached in Annex 14 is the analysis sheet for the month of October 1990, showing total to date expenditures and the budget balance. As is evident from this sheet there is only a large over spend in medical supplies category. This was noticed by the Management and efforts are being made to cut down the expenses and regularize the supplies according to the budget.

Reasons for the underspend in various line items are as follows:

a. <u>SALARIES AND STAFF BENEFITS</u>

This is due to not employing the intended staff, mentioned in the budget upto October 1990. These staff will be employed within the next few months. This underspending will be further reduced after the payment of Christmas bonus to all the staff with December salaries.

Also the Project Management has decided to discontinue the uniform allowance to the staff and instead provide them accidental insurance cover for one year. The premium amounting Rs.53,757.00 was paid from the same category during November 1990.

b. STAFF TRAINING

Most of the staff have attended training courses and some of them will be attending these courses within the next few months. We are awaiting charges from Pakistan Institute of Management which will reduce the underspending in this category.

SECTION IV

FUTURE PLANNING

WORK INSIDE AFGHANISTAN

In December 1988, the Project Director prepared a concept paper regarding the idea of creating an indigenous Afghan NGO which could then go to Afghanistan and work to assist and encourage a repatriation of the refugees living in Pakistan, also assisting the internally displaced people who number about 2.3 million.

As mentioned in our report of June 1990 and also earlier in this report, The Salvation Army has been able to create an indigenous Afghan NGO named the Afghan Development Agency (ADA) in October 1990. It has been decided that in the beginning the staff of this NGO who are also The Salvation Army staff, will implement the existing Salvation Army Vocational Training and Income Generation projects in the camps and will commence work as Afghan Development Agency (ADA) in Afghanistan. After a period of two years, or earlier as mutually agreed by Salvation Army and Afghan Development Agency, ADA will become independent and will implement all its own programmes.



SECTION II

BASIC MEDICAL PROGRAMME

OPERATIONAL DETAILS

INTRODUCTION

The basic medical programme commenced with the inception of the project in August,1982 in Ghazi refugee camps.

In the beginning there were only two basic health units but four more BHUs were later added in Haripur camps, thus bringing the total number of BHUs to six. All these BHUs were established on the request of Project Director Health for Afghan Refugees, N.W.F.P., who is responsible for providing health facilities to the Afghan Refugees residing in the N.W.F.P.

Through these basic health units, the project is providing Comprehensive Primary Health Care services to the refugee community.

At the commencement of the project, only curative health facilities were provided but it was soon realized that the number of patients visiting the BHUs was considerably increasing. After realizing this fact efforts were made to find out the reasons for the increase in the illnesses and it was found that most of the patients suffered from common communicable diseases which could be easily prevented by adopting certain preventive measures and in most of the cases it was found that women and children were most affected.

It was then realized that curative facilities will not bear any fruit unless something is done to prevent these diseases from occurring and there is a need to create awareness among the refugees especially the women and children.

Due to this the project management reconsidered their programmes of curative health and worked more vigorously to evolve plans and strategies to cope with the challenge of communicable diseases.

The project introduced a preventive health aspect in the medical programme and commenced with the recruitment of female staff. This was due to the fact that they are better accepted among the refugee population than the men, because of the cultural and traditional beliefs.

THE SALVATION ARMY
AFGHAN REFUGEE ASSISTANCE PROJECT
MEDICAL STATISTICS

SIX MONTHLY REPORT

Province N.W.F.P District/Agency: ABBOTTABAD

RV: HARIPUR & GHAZI BHU: 1,2,3,4,5 & 6 MONTH: May to October' 90

Organisation: The Salvation Army, Afghan Refugee Assistance Project.

Nature of Sickness	Men	Women	0-4 Children	4-15	Total
Eye infection	437	431	550	695	2113
Ear infection	200	283	632	711	1826
Upper respiratory infection	3260	3654	4740	5256	16910
Bronchitis	725	1655	81	303	2764
T.B. suspected	92	255	45	191	583
T.B. confirmed	110	236	2	-	348
Diarrhoea	580	338	3236	1959	6113
Dysentery	672	595	1985	1359	4611
Worms	238	171	292	1004	1705
Other gastric problem	1490	3287	1550	1072	7399
Urinary tract	680	726	64	153	1723
Nervous system	66	37	-	9	112
Joint/Bones	379	351	25	60	815
Skin disease	1810	2064	2649	3966	10489
Malaria	169	88	24	178	459
Fever (P.U.O.)	989	2376	2570	3140	9075
Anaemia	350	762	168	382	1662
Malnutrition: 1st Degree	-	-	1717	-	1717
2nd Degree	-	-	1035	-	1035
3rd Degree	-	-	481	-	481

Turn over please

Nature of Sickness	Men	Women	0-4 Children 4-15		Total
Obstetric	-	5600	-	-	5600
Gynaecological	-	1754	-	-	1754
Dental	90	119	8	46	263
Psychosomatic illness	2161	4133	2	432	6728
Other (Specify if notifiable)infections disease. goitre i.e)	880	1947	252	283	3362
Measles	-	-	12	2	14
Mumps	1	2	4	10	17
Jaundice	49	23	17	38	127
Typhoid	14	6	-	16	36
Total	15442	30893	22141	21365	89841

No. of referrals 650 Patients reffered to Govt Hospital from the BHUs

37771 Patients reffered to BHUs by the CHWs

For further details please see enclosed reports

Staff:

Medical Officer: 6 LHV: 11 Compounder/Dispenser: 6 Dai: 4

Malaria Supervisor/ Sanitary Inspector: 6/3 Vaccinator/ Motivator: 7 Nursing Orderly: 3 Other 18

Traditional Birth Attendant (TBA) / Community Health Worker (CHW): 6/431 TBA trainee/ CHW trainee: 2

Ambulance: 1 Other vehicles (Specify) 4 Pajero wagons 2 Toyota Pickup, 1 Ford Transist

Date

Programme Officer

THE SALVATION ARMY

AFGHAN REFUGEE ASSISTANCE PROJECT

LABORATORY STATISTICS

Reporting Period May-Oct. 90. Camp Haripur & Ghazi. BHU NO: 1,2,3,4,5 & 6

No.	Specimen	Test Requested	Normal/-Ve	Abnormal/+Ve	Total
1.	BLOOD	T.L.C. + D.L.C.	190	101	291
		E.S.R.	25	33	58
		Hb%	36	41	77
		Widal.	96	26	122
		M.P.	11,285	1,544	12,829
		Sugar.	- NIL -	1	1
		Group/Rh Factor	13	- NIL -	13
		V.D.R.L.	- NIL -	- NIL -	- NIL -
		TOTAL	11,645	1,746	13,391
2.	URINE	Cells.	138	138	276
		Sugar.	51	5	56
		Urobilinogin.	58	8	66
		Albumin	20	123	143
		TOTAL	267	274	541
3.	SPUTUM	A.F.B.	811	49	860
4.	STOOL	R. Worm.	24	2	26
		H. Worm.	26	7	33
		T. Worm.	26	- NIL -	26
		W. Worm.	26	- NIL -	26
		H. Nana.	25	1	26
		E. Histolytica.	20	16	36
		Occult Blood.	25	1	26
		Rutine Exam.	21	7	28
		Giardia.	7	1	8
		TOTAL	200	35	235
5.	ANY OTHER	Urine Pregnancy.	48	30	78
		Semen Analysis.	- NIL -	2	2
		GRAND TOTAL	12,971	2,136	15,107

Remarks:__________

Programme Officer.

TB CONTROL PROGRAMME - AFGHAN REFUGEES
PAKISTAN GOVT / UNHCR / WHO / ITALIAN COOPERATION FOR DEVELOPMENT

SIX MONTHLY REPORT

BHU: 1,2,3,4,5 & 6 PERIOD May to October, 90

DISTRICT: Haripur and Ghazi AGENCY: The Salvation Army

A. CASE-FINDING ACTIVITIES BY MICROSCOPIC EXAMINATION

Microscopy / Type of Patients	Number of slides examined	Number of slides found positive	Number of patients examined	Number of patients found positive
New attendants of the clinic	680	30	259	13
Under treatment (old patients)	176	17	80	9
Total	856	47	339	22

B. TREATMENT ACTIVITIES

Cases	Type of disease	No. of Pulmonary (P) cases			No. of Extra-Pulmonary Cases (EP)
		Smear* Positive	Smear Negative	Total	
(a)	Under treatment at the end of previous period	23	11	34	29
(b) Input	New cases registered during this period	14	9	23	18
	Starting again during this month after being lost	1	-	1	-
	Transferred in during this period	1	-	1	3
(c)	Total input = (a)+(b)	39	20	59	50
Output	Completing the treatment * during this period	8	11	19	14
	Died during this period	-	-	-	-
	Transferred out during this period	3	1	4	1
	Lost during this period	2	-	2	-
(d)	Total output	13	12	25	15
(e)	Under treatment at the end of this period = (c)-(d)	26	8	34	35

Note: Please, indicate the number of defaulters during this period. p:(+)Nil
(-)Nil
EP: 1

* Smear - positive in this column shall refer to patients
Whose sputa were positive at the start of treatment.

ANNEX.4

THE SALVATION ARMY
AFGHAN REFUGEE ASSISTANCE PROJECT
MALARIA SUPERVISORS
REPORT FORM

Reporting Period 1st May-31st Oct' 1990 Camp Haripur & Ghazi BHU NO: 1, 2, 3, 4, 5 & 6

A. Malaria Control Activities:

Total Slides Collected (1 Per Case)	Positive Case				Negative Cases	Cases Treated	Un Treated	Remarks
	P.V	P.F	P.M	TOTAL				
12,829	1409	134	1	1544	11,285	1544	-Nil-	-Nil-

B. T.B. Control Activities:

Total Slides Collected / Fixed : 863

Programme Officer.

ANNEX.5

THE SALVATION ARMY

AFGHAN REFUGEE ASSISTANCE PROJECT

PREVENTIVE HEALTH TEAM (FEMALE)

Reporting Period 1st May-31st Oct' 1990 Camp Haripur & Ghazi BHU NO: 1,2,3,4,5 & 6

Antenatal Clinic

a	Under care at the end of previous month.	621
b	New cases registered this month.	1187
c	Total = (a + b)	1808
	Live births during this month.	971
	Stillbirths during this month.	23
d	Untraceable after e.d.d.	25
	Total.	1019
e	Under care at the end of this month = (c - d)	789

Deliveries

Deliveries assisted by staff	280
Deliveries assisted by T.B.A.s	241
Deliveries assisted by F.H.W.s	86
Total deliveries assisted	607

Mortality

Maternal deaths	4
Infant deaths	35

Remarks: Defaultters = 51

Programme Officer.

ANNEX.6

THE SALVATION ARMY

AFGHAN REFUGEE ASSISTANCE PROJECT

PREVENTIVE HEALTH TEAM (FEMALE)

Reporting Period 1st May-31st Oct' 1990. Camp Haripur & Ghazi BHU NO: 1,2,3,4,5, & 6

	Under two Clinic	
a	Registered at the end of previous period.	2707
b	Newly registered this period.	1183
c	Total = (a + b)	3890
	Children older than two.	532
	Deaths this period.	35
	Lost	862
d	Total.	1429
e	Registered at the end of this period=(c-d)	2461
	Total attendances this period.	6081

Degree of malnutrition.	1st	2nd	3rd	Total
Underwight no.	340	206	101	647
Considerably improved.	88	73	31	192
Defalters *	56	41	43	140

* Defaulter (healthy) if child misses two months
(1st degree) if child misses one month
(2nd degree) if child misses one month
(3rd degree) if child misses two weeks

Health Education.		No. of attendances.	Number of lectures.
Schools.		4,135	39 Lectures.
B.H.U.		58,096	1202 Lectures.
Home Visits	Women	17,617	1,120
	Antenatal.	1,929	
	Postnatal.	1,798	
	Children.	17,661	

Remarks: Health education in schools could not be imparted because of summer vacation

Topics Covered: Weaning Food, Personal, T.B, Hygiene, Home Sanitation, Breast Feeding, Vaccination, Clean Water, Jaundice, Fever, Skin Infection, Care of New Born, Malaria, Immunisation, Diarrhoea,Growth Chart, Burns, Protection from Flies, Antinatal Diet,Worms, Postnatal care , Advantages of U-2 Cards, Danger of bottle feeding.

Programme Officer.

ANNEX.7

THE SALVATION ARMY

AFGHAN REFUGEE ASSISTANCE PROJECT

EXPANDED PROGRAMME ON IMMUNISATION

VACCINATION COMPLETION REPORT

Reporting Period 1st May-31st Oct' 1990. Camp Haripur & Ghazi BHU NO: 1,2,3,4,5 & 6

Age Group	Attendances this period	Vaccination completed this period						Completely Vaccinated	
		B.C.G.	Polio III+ Br	D.P.T. III+Br	D.T. II + Br	T.T. II + Br	Measles	This Period	Cumulative Since May90
Women (C.B.A)	4777	==========	==========	==========	==========	3135	==========	1443	1443
CHILDREN 0-11 Months	6297	1263	1366	1366			1427	1419	1419
12-23 Months	204	19	150	150			35	31	31
2 - 4 Years									
5 + Years									
TOTAL	6501	1282	1516	1516		3135	1462	1450	1450

Programme Officer.

The Salvation Army
Afghan Refugee Assistance Project,
Pakistan PD - 734 (III).

Afghan Refugee Health Programme
Expanded Programme on Immunisation

SIX
MONTHLY REPORT

1. Immunisation preformed during 1st May - 31st October' 1990. BHU 1,2,3,4,5 & 6 RV Haripur & Ghazi

Age Group	POLIO 0	B.C.G	POLIO				D.P.T.				T.T.					Measles	Total atte-nd.	F.I. U.1.
			I	II	III	Br.	I	II	III	Br.	I	II	III	IV	V			
0-11 Months	780	1263	1269	1292	1366	-	1269	1292	1366	-	-	-	-	-	-	1427	6297	1419
12-23 Months	-	19	20	21	24	126	20	21	24	126	-	-	-	-	-	35	204	4
2-4 Years	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
5 + Years	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Women (15-45)	-	-	-	-	-	-	-	-	-	-	1642	1438	1194	492	11	-	4777	-
Total	780	1282	1289	1313	1390	126	1289	1313	1390	126	1642	1438	1194	492	11	1462	11278	1423
2. Uptodate work done since 19 todate during th current project PD																		
0-11 Months																		
12-23 Months																		
2-4 Years																		
5 + Years																		
Women (15-45)																		
Total																		

Signature ____________________
Programme Officer.

THE SALVATION ARMY

AFGHAN REFUGEE ASSISTANCE PROJECT

PREVENTIVE HEALTH TEAM (MALE)

Reporting Period 1st May-31st Oct' 1990 Camp Haripur & Ghazi BHU NO: 1,2,3,4,5 & 6

Health Education		
	No. of attendances	No. of talks
Camps	35023	314
Schools	16417	324
B.H.U.s	18233	643

Topics Covered :- Tetanus, Malaria, T.B., Clean Water, Dirty Hands,Blood transfusion, Polio, Personal Hygiene, Dysentery, Measles, Worms, Wounds, Care of children, Immunisation, Balance Diet, Asthema, Sanitation, O.R.S, Skin disease, Eye infection.

Camp Sanitation Inspection			
No of pit latrines	5786	Inspected	28004
No of watertanks	166	Inspected	480
No of taps	69	Inspected	414
No of wells	474	Inspected	2226

Other Activities / Remarks.

Health Motivation	Contacted	Visited B.H.U.
T.B. defaulters.	13	12
Undertwo's for vaccination.	15167	9228
Malaria cases for radical treatment.	578	365
Under-2 Defaulters.	465	390

Birth and Death Record		
Births Recorded		695
Deaths Recorded	Underfives	75
	Adults	50

Causes of death:

Programme Officer.

Three preventive health teams, headed by a Female Medical Officer and female support staff were added to the already existing three curative health teams headed by Male Medical Officers and their male support staff, both at Haripur and Ghazi camps.

Three Public Health teams, headed by a sanitarian and project trained Community Health Supervisors (CHS) and Community Health Workers were also deployed in the six BHUs to work on alternate days and implement their programme of creating awareness among the people through health education.

In this period, these Curative, Preventive and Public health teams were combined to provide a comprehensive Primary Health Care approach.

The overall medical programme of The Salvation Army, Afghan Refugee Assistance Project revolves around the following four major objectives:

1. ***TO IMPROVE THE GENERAL HEALTH OF THE REFUGEE POPULATION.***
2. ***TO CATER FOR MEDICAL EMERGENCIES.***
3. ***TO DECREASE THE INCIDENCE OF COMMUNICABLE DISEASES.***
4. ***TO IMPROVE THE KNOWLEDGE OF THE COMMUNITY REGARDING PREVENTIVE HEALTH PRACTICES.***

HEALTH PROGRAMME DEVELOPMENT

During the current reporting period some major changes have been brought about in our Basic Medical Programme. These changes are as follows:

1. INTEGRATION OF PROGRAMMES

As has been mentioned in our last report, the project was planning to integrate its Basic Medical and Community Health Education Programmes to give birth to a Comprehensive Primary Health Care Programme. The Project Management are happy to inform that this has been accomplished and now both medical and health education programmes are being implemented in consultation with each other.

Besides this the Project Management commissioned the idea of an Internal Medical Services Analysis in order to assess the Medical and Health Education programmes. Another reason for this was to bring about some changes in the programme and emphasise more on the preventive side as opposed to the

THE SALVATION ARMY

AFGHAN REFUGEE ASSISTANCE PROJECT

MEDICAL STATISTICS (Minor Surgery)

Reporting Period 1st May-31st Oct'1990 Camp Haripur & Ghazi BHU NO: 1,2,3,4,5 & 6

Total Number of Attendances 17751

Minor Surgery

Injections	Wound Dressing	Burns Dressing	Abscess I / D	Stitching	Total
7314	9511	519	364	43	17751

Circumcisions: 28

Ear Wash: 6

Remarks: 18 are incidence of Burns.

Programme Officer.

ANNEX. 11



THE SALVATION ARMY
Afghan Refugee Assistance Project
PAKISTAN

A HISTORY
OF
THE DEVELOPMENT
OF AN
AFGHAN NON-GOVERNMENTAL ORGANISATION

The Salvation Army Story

Captain Ivor S. Telfer
THE SALVATION ARMY
Afghan Refugee Assistance Project
PESHAWAR
November 1990.



THE SALVATION ARMY
Afghan Refugee Assistance Project
PAKISTAN

LIST OF CONTENTS



THE SALVATION ARMY

Afghan Refugee Assistance Project

PAKISTAN

A HISTORY OF THE DEVELOPMENT OF AN AFGHAN NON-GOVERNMENTAL ORGANISATION

THE SALVATION ARMY STORY

PURPOSE

The purpose of this document is to record the procedures of The Salvation Army Afghan Refugee Assistance Project (SAARAP) in the formation of a totally independent Afghan Non-Governmental Organisation (ANGO) from within The Salvation Army project.

INTRODUCTION

If by recording this process specifically for The Salvation Army, it serves to assist other organisations or individuals in the correct formation of suitable and relevant ANGOs, then this documentation will have served an additionally useful purpose.

It is vital to note that The Salvation Army and in particular this writer are not advocating the proliferation of ANGOs but in fact the reverse. Too many people have and still are attempting to "jump on the band wagon" and be the first to create an ANGO or to create the biggest or to attempt to solve the problem of Aid to Afghanistan by creating such ANGOs.

All that is shown by such people is their lack of knowledge about the Afghan nation, its culture and its history. This writer claims very little knowledge of Afghan people, culture or history but has been working with and listening to Afghan people for the past two years, thereby enabling him to realise how little he does know and therefore to listen more and speak less. This document attempts to record what the writer has heard and taken in and in no way tries to be exclusive or all inclusive about the culture and history of the Afghan nation as it relates to this issue.

ACKNOWLEDGMENTS

The writer acknowledges the invaluable contributions of many people in assisting to come to this stage in the creation of an ANGO. The problem with naming these people is that always some are left out but a few must be mentioned because of their vast contribution to this process.

Firstly **Major and Mrs. David and Jean Burrows** of The Salvation Army, International Headquarters, London who commenced The Salvation Army Afghan Refugee Assistance Project in 1982 need to be acknowledged. Had they at that time brought in other expatriates as senior staff or had they chosen senior staff carelessly, this process would not have been possible.



THE SALVATION ARMY

Afghan Refugee Assistance Project

PAKISTAN

Secondly sincere appreciations to **Wim and Corrie Kanis**, respectively the Field Programme Co-ordinator and Primary Health Care Advisor of the project from 1986-1988. If they had not been able to respond to the changing situations and further develop

the structure of SAARAP, this process would not have been possible.

Thirdly the contribution of **Colonel John Nelson**, the Territorial Commander of The Salvation Army in Pakistan needs to be recorded. His patience with the writer during the process to create this ANGO together with his support for the concept allowed further development to take place and assisted in the approval of The Salvation Army, International Headquarters, London to this new venture.

Many other people have assisted in various ways and continue to do so and sincere thanks are extended to each one of them.

However, of extreme importance are two staff members who have been involved closely with the writer since the germination of the idea in late 1988.

These are **Mr. Syed Mehmood Asghar**, Manager Administration of SAARAP and **Mr. Ghulam Jelani Popal**, Programme Officer for Vocational Training and Income Generation of SAARAP and the Managing Director of the ANGO, **AFGHAN DEVELOPMENT AGENCY** (ADA).

This record is of the work undertaken specifically by these two people and the writer. Without them, this ANGO would not be a reality.

Finally, it must be emphasised that this document is not meant to be **THE WAY** either to create an ANGO or to solve the problem of appropriate and sustainable aid to Afghanistan, but indeed is a record of what the writer, The Salvation Army and the senior Afghan and Pakistani staff feel is **appropriate in our situation. No generalisations should be taken** from this document but if anything can be learned from it, this may prevent future problems for the Afghan people and the aid community.



THE SALVATION ARMY

Afghan Refugee Assistance Project

PAKISTAN

IN THE BEGINNING

Since 1979 over five million Afghans have been forced to leave their country, about three and a half million of them finding shelter in Pakistan. They have been housed in approximately 380 refugee camps, mainly in the North West Frontier Province of Pakistan, living at first in tents but now mostly living in their own constructed mud brick houses in the refugee camps.

The Salvation Army, who has been working in the Indian Sub-Continent since 1883, commenced its work with the Afghan refugees in 1982 in the Ghazi area, giving emergency aid to the newly arriving refugees and then establishing two Basic Health Units (BHUs) and a field laboratory.

It was at this point that SAARAP took **two decisions** that were to affect the whole future thinking of the project.

1) **A MINIMUM NUMBER OF EXPATRIATES**

According to regular Salvation Army policy in developing countries, the expatriate presence is kept to a minimum and is meant to re-inforce the local people, ie. help them to help themselves. Due to this, only two expatriate people were directly connected with the project and this was a policy which continues to the present. The only exception to this being the temporary assistance of three volunteers, one for three months and the other two for eleven months.

Keeping the expatriate presence to a minimum forced the expatriates to listen to the local Afghan and Pakistani staff and thereby to develop appropriate projects and systems.

2) **CAREFUL SELECTION OF LOCAL STAFF**

Due to the careful selection of both Afghan and Pakistani senior staff, two benefits have accrued :-

a) **A sense of ownership of the project by the staff.** This has shown in the day to day dedication and decision making of these staff.

b) **Longevity of employment with SAARAP.** The Managing Director of ADA has been with the project since 1982, being the second staff member employed and the Administration Manager joined in 1983. Also 7 staff have received seven year certificates and 37 staff have received five year awards, out of a project staff of approximately 200.

If these two conscious decisions had not been made, SAARAP's programmes and the present project would have developed in a different manner and this document would not have been written or indeed necessary.



THE SALVATION ARMY
Afghan Refugee Assistance Project
PAKISTAN

IN THE MIDDLE

Once SAARAP had commenced in Ghazi looking after the health care of approximately 25,000 refugees, it was noticed that many of the patients attending the BHU were suffering from psychosomatic illnesses. When this was further investigated it was clear that the men were not used to being idle and the women were not used to having to remain indoors.

Prior to coming to Pakistan, the men were working in the fields and the women were free to move around within their own extended family group and would only have to observe purdah when a non-family member came into the area. However in the cramped living conditions which exist in the refugee camps, the "purdah free" area was much smaller, the women having to literally remain in their own home.

SAARAP commenced some income generation programmes to assist these refugees with psychosomatic related diseases and this was entrusted to the management of an Afghan.

Later in 1984, SAARAP was requested by the Government of Pakistan to take over the health care of approximately 65,000 refugees in five camps in the Haripur area and SAARAP established four basic health units in Haripur.

Further work was implemented in income generation and vocational training was also commenced.

By the time the writer arrived at the project in August 1988, a medical programme, vocational training and income generation programmes and a community health education programme were established and running smoothly.



THE SALVATION ARMY
Afghan Refugee Assistance Project
PAKISTAN

THE GERMINATION OF THE IDEA FOR AN AFGHAN N.G.O.

In late 1988, a retreat was organised for the senior staff of SAARAP to review the programme and plan for the future work. Here of course it must be remembered that many agencies were commencing to plan for a repatriation and these thoughts came into play in this retreat.

Further, the staff looked at the long term future for the project and after the retreat, the writer felt that the best long term solution to the continuance of the aid programmes was to indigenise them, ie. give them over totally to the Afghans to care for the Afghans.

This idea developed and in further conversations the idea of an Afghan NGO was formed.

Since December 1988 much work has progressed on this matter and this is now detailed below.

WHAT IS AN AFGHAN N.G.O. ?

This area is not being dealt with here as many people and agencies have their own ideas about what this should be. It is here sufficient to say that in this case, this Afghan N.G.O. has the following elements :-

1) A Board of Directors who are predominantly Afghan.
2) The Director of the agency is Afghan.
3) They have a constitution.
4) They do not have any international office.
5) They exist for the benefit of the Afghan people.
6) They are non profit making.
7) They have only humanitarian aims.
8) They are independent of control by any political party or government.
9) They are independent of control by any other aid agency or donor, other than by basic contractual obligations.

It must however be noted that if a local shura approaches a donor or U.N. Agency for funding, **they must not be confused as being an Afghan NGO and also should not be forced to become an ANGO. They are simply a local implementing partner and as such should remain in that form.**



THE SALVATION ARMY

Afghan Refugee Assistance Project

PAKISTAN

NECESSARY STEPS IN THE FORMATION OF AN ANGO

The next steps in this process are outlined in the attached Annex No. 1 entitled "**HOW TO GIVE BIRTH TO AN AFGHAN N.G.O.**" prepared by the writer and Mr. Jelani on 6th. September 1989. Obviously some of the "Internal Steps" have not been implemented in the way planned but generally this document outlines the main steps necessary to be taken by SAARAP in their wish to "Afghanise or De-foreignise" as this is now being called.

Basically, these main steps are that

1) there must be a genuine desire on the part of the Western N.G.O. (WENGO) and the Afghan staff to commence an ANGO.

2) the WENGO must actively prepare and implement steps to enable the Afghan future staff of the ANGO to receive the necessary project implementation skills, financial and administrative skills, setting up appropriate low technology systems which can be effectively maintained by the Afghans to ensure correct recording/reporting requirements by donors can be met. These steps must include where possible, having Afghans in senior decision making positions.

a) This process must be implemented over a **long period** and cannot be ensured after a few weeks as some agencies are suggesting. The time-table depends on the existing abilities of the Afghans and the extent to which the WENGO has already devolved decision making to the Afghans.

IT MUST BE EMPHASISED THAT THIS PROCESS CANNOT HAPPEN QUICKLY AND ANY AGENCY WHO FEELS THAT THIS IS THE SIMPLE ANSWER TO THEIR FUTURE OR TO THE PROBLEM OF AID TO THE AFGHAN PEOPLE SHOULD NOT COMMENCE ON SUCH A VENTURE.

b) Active and relevant technical assistance must be commenced by the WENGO. The counterpart idea (where an Afghan is employed to do the same job as the expatriate with a view to him replacing the expatriate at some suitable point) is not recommended by the writer but instead relevant on-the-job technical assistance, complimented by **relevant** courses and **appropriate** methods which can be implemented in Afghan culture are necessary.



curative side so that this could be easily transferred to Afghanistan at the time of repatriation, creating less problems for the refugees who are now very much dependent on curative medicine.

The project management is still continuing with the implementation of the proposed changes on its own initiative and hopefully by the end of the current grant period, all the changes would have been introduced in the programme. An important point to note is that total ownership of the changes in the programme has been achieved at all staff levels due to the internal consultation during the Internal Medical Services Analysis.

2. <u>TRAINING OF STAFF</u>

Another step taken by the project to prepare refugees for repatriation was to train para-medical and other BHU staff like CHSs, CHWs and Sanitarians in other disciplines also so that they could use their training in their areas, after repatriation, in the absence of needed para medical staff.

In this connection a total of 39 refugee staff have been trained in giving vaccines, treatment and dressing of wounds, and treatment and control of malaria.

3. <u>REDUCING THE EMPHASIS ON MEDICINES</u>

Similarly, the medicines list has been cut down from 103 in January 1990 to 77 at the date of this report. Also the medicines now on the list are mostly generics. Also the prescription of medicines in the BHUs has been reduced to a maximum of 3 medicines per patient.
Annex 12 is the revised medicines list.

4. <u>MORE EMPHASIS ON HEALTH EDUCATION</u>

As previously mentioned, more emphasis is being given on health education to the refugees. For this reason a separate room has been constructed in each BHU to give health talks to all the refugee patients attending the BHU for the treatment of different diseases.

All the patients have to go through this room and they will not receive any medication from the doctor unless they are exposed to a health talk by one of the BHU staff.



THE SALVATION ARMY

Afghan Refugee Assistance Project

PAKISTAN

CRITERIA FOR BOARD MEMBERSHIP

For correctly created ANGOs to be acceptable there are some basic points which must be borne in mind.

1) The Director and board members of such an ANGO must be people who come from a highly respected family who have always had much influence in the geographic location in which the ANGO wishes to work. If this is not the case then the aid agencies will be guilty of the same problems that have been committed by others - elevating the wrong people to positions of influence. For expatriates to be sure that such family influence has been correctly judged is almost impossible and much careful counsel must be sought. However, to ignore this vital point is not only going to cause problems for the people with whom the ANGO is to work, but also it will cause inconsistent implementation of projects in that area.

2) The second vital criteria is to ensure that no over - emphasis is placed on party membership of the senior Afghans of the ANGO. As family/tribal ties are generally of more importance than party affiliations, it is probably erroneous to assume that one party dominance in the Boardroom will ensure smoother operations.

3) Projects should only be implemented in areas where either there is a family/tribal influence as 1) above or where there is a "class-fellow who is a friend" relationship. This latter relationship is where a commander, influential leader or member of a shura was in the same faculty of the university and a close friend of one of the board members of the ANGO. This relationship is secondary only to the family/tribal relationship.

It must be noted that the above is not intended to be **THE WAY** to ensure safe and correct implementation of projects but merely to list factors which must be taken into account in the formation of an ANGO, if this is to be culturally acceptable in Afghan society today.

Are Afghan NGOs acceptable in Afghan culture? This is yet to be determined. However, if ANGOs are sensibly and sensitively created, they undoubtedly will have a better chance of survival and of relating to the future Government of Afghanistan if they have been formed in the above manner.

Should ANGOs have no long term future, then the training and expertise received by the Afghans will assist them in the future rebuilding of their country through various central assistance programmes.



THE SALVATION ARMY
Afghan Refugee Assistance Project
PAKISTAN

ARE ANGOs ACCEPTABLE IN AFGHAN CULTURE ?

This is, of course, a very hard question and many people much more knowledgeable than this writer could write papers for and against such an idea. However what this writer attempts to do here is only to mention some of what he feels are the most important points which must be borne in mind by expatriates in their thinking about the creation of ANGOs.

THE TRADITIONAL POWER STRUCTURE IN AFGHANISTAN

There is correctly much concern about how the traditional power structure in Afghanistan has been upset by the past years of conflict.

Previously the Government policy was to invite the support of the "grey beards" from the local areas. These "grey beards" were represented in the Senate and the National Assembly and thereby the Government had the consensus of the people in these areas.

Due to the war, in some areas a local good fighter has been elevated to the position of a commander by being given arms and supplies from foreign powers to fight against the Soviets. While it is accepted that in some cases the local commander was an influential person in the area, in many cases this was not the case.

In these latter situations, the commander, a good fighter and capable warrior, often assumes more importance that the "grey beards" of the area and the tribal leaders end up having little or no power in the area. It is comforting to see that in a few situations where this has happened that the commander is now one of the tribal leaders and the traditional customary "government" of the area by the "grey beards"/ tribal leaders is returning.

Much has already been written about the problems the aid agencies have caused for themselves and the Afghan people by not working correctly through the existing structures in areas (See Paktika Task Force paper) and no more will be mentioned here.

However, this upsetting of the existing structures brings into question the whole concept of Afghan Non-Governmental Organisations, a concept which did not exist in Afghanistan before the war.

There are people who feel that because they did not exist before the war, they should not exist now. They may be correct, but this writer together with his senior staff, thinks that correctly created ANGOs do have a place in Afghan society.



THE SALVATION ARMY
Afghan Refugee Assistance Project
PAKISTAN

CONTINUING TECHNICAL ASSISTANCE

The need for technical assistance has already been alluded to above and at present SAARAP is giving this, principally in the areas of administration and finance, while ADA is still connected with SAARAP. However, the whole area of technical assistance is badly neglected by donors in general.

For relevant, sustainable, correctly culturally constituted ANGOs to not only survive but perform a much needed professional task in Afghanistan, any appropriate low cost technical assistance is vital.

To this end, the present investigations and proposals for such assistance receive this writer's full support provided that

1) the proposals are of such low cost that developing ANGOs can afford to avail themselves of this technical assistance and

2) they are teaching culturally appropriate methodology and not only that which is appropriate in a western country.

IN CONCLUSION

It must be emphasised once again that this is not **THE WAY** and it is not intended that other agencies should attempt to copy this type of procedure. It has been felt necessary by The Salvation Army to move in this direction and also it is in line with Salvation Army procedures which are always aimed at **helping the people to help themselves.**

The writer leaves with you a verse extremely appropriate :-

GO TO THE PEOPLE
LIVE AMONG THEM,
LEARN FROM THEM,
LOVE THEM,
START WITH WHAT THEY KNOW,
BUILD ON WHAT THEY HAVE:
BUT OF THE BEST LEADERS
WHEN THEIR TASK IS ACCOMPLISHED,
THEIR WORK IS DONE,
THE PEOPLE ALL REMARK,
" WE HAVE DONE IT OURSELVES".
(ANON)

IVOR S. TELFER. CAPTAIN.
DIRECTOR.
PESHAWAR
13TH. NOVEMBER 1990



THE SALVATION ARMY

Afghan Refugee Assistance Project

PAKISTAN

SUSTAINABILITY OF AN AFGHAN N.G.O.

This matter has been left to the latter part of this document as it is of vital importance in the present donor climate, in the future of Afghanistan and also has been largely overlooked by NGOs, the UN and donors alike. Undernoted is the outline plans for ADA relating to sustainability but in detailing these it must be noted that all agencies are working very much in a fluid situation and if aims are not immediately realised, neither the idea nor the ANGO should be discarded, but the ultimate aim must be reached for.

In the specific case of ADA, the NGO has been set up to implement income generation and vocational training programmes.

At present, the staff are involved in the implementation of the following programmes:- leatherwork production, soap making, embroidery, gillim weaving, carpet weaving, food preservation training, training in welding, carpentry, tractor repair, vehicle repair and car body repair.

Of these projects, the leatherwork project is now self-supporting, ie. it can continue to work due to the income from its sales. Leather goods, including leather gillim combination bags are being exported to the Netherlands, Australia, U.K. (through Ockenden Venture) and a few orders have been received from the U.S.A. Further the project has a shop in Murree and sells locally through Ockenden Venture and also through SCF(US) in Islamabad and Lahore, apart from various exhibitions.

Eventually, it is hoped that the food preservation training programme may be able to be self supporting and the soap making, together with a lesser degree the training, hopes to become self supporting.

In Afghanistan, this type of village based appropriate work is necessary and could eventually be implemented by a sustainable system, instead of at present where most projects can only operate if donors fund.

This whole issue needs much more examination and it is the intention of the ANGO to pursue this further as part of its future development.

THE SALVATION ARMY
Afghan Refugee Assistance Project

Medicine List.

S.No	NAME OF MEDICINE	QUANTITY	MEDICINE CEN			
1.	Capsule Amoxil (Beecham) 250 mg.	1 X 500	805.00			
2.	Tablets Co-Trimexazole. (Local)	1 X 200	70.00			
3.	Syrup Septran. (Wellcome)	EACH	8.90			
4.	Tablets Penicillin V. 250 mg (Glaxo)	1 X 200	6.38			
5.	Syrup Omnipen (Imported)	EACH	6.50			
6.	Drops Ampiclox (Beecham) 8 ml.	EACH	12.50			
7.	Tablets Brufen (Local) 400 mg.	1 X 500	200.00			
8.	Tablets Paracetamol (Nicholas).	1 X 200	27.00			
9.	Tablets Aspirin.	1 X 1000	43.00			
10.	Tablets Actifed P (Wellcome).	1 X 400	148.00			
11.	Drops Pipcalm (SDH)	EACH	8.80			
12.	Tablets Resochin (Bayer) 250 mg.	1 X 300	82.00			
13.	Syrup Chloroquin (Nabi Qasim).	EACH	4.00			
14.	Tablets Trisil (Efroze) 500 mg.	1 X 1000	73.00			
15.	Mixture Carminative (Bliss).	EACH	5.10			
16.	Tablets Hyoscine Compound.	1 X 100	28.00			
17.	Tablets Entox (Wyeth).	1 X 100	33.00			
18.	Tablets Flagyl (M & B) 200 mg.	1 X 100	51.00			
19.	Syrup Metromidazole. (Local)	EACH	8.50			
20.	Tablets Combantrain (Pfizer) 250 mg.	1 X 100	262.00			
21.	Suspension Combantrin (Pfizer).	EACH	6.30			
22.	Tablets Avomin (M & B).	1 X 100	17.50			
23.	Syrup Maxolon (Beecham).	EACH	6.80			
24.	Syrup Benadryl Exp. (Parke Davis).	EACH	5.30			
25.	Syrup Abenol Plus (Popular).	EACH	6.80			

THE SALVATION ARMY

Afghan Refugee Assistance Project

Medicine List.

S.NO	NAME OF MEDICINE	QUANTITY	MEDICINE CEN			
26.	Tablets Ventolin (Local) 100 mg.	1 X 20	6.60			
27.	Syrup Ventolin (Glaxo). 60 ml	EACH	9.40			
28.	Powder Cicatrin.	EACH	5.95			
29.	Cream Burnol (Boots) 30 mg.	EACH	4.40			
30.	Ointment Betnovate N (Glaxo) 15 mg.	EACH	8.25			
31.	Ointment (Mycota) 28 mg.	EACH	7.25			
32.	Solution Ascabiol (M & B).	EACH	5.95			
33.	Tablets Avil (Hoechst) 25 mg.	1 X 250	36.00			
34.	Syrup Phnergan (M & B).	EACH	5.75			
35.	Tablets Deltacortil (Pfizer) 5 mg.	1 X 540	105.00			
36.	Tablets Aldomet (MSD) 250 mg.	1 X 100	75.00			
37.	Tablets Inderal (ICI) 10 mg.	1 X 50	27.70			
38.	Tablets Moduretic.	1 X 100	91.00			
39	Tablets Diazepam (Imported) 5 mg.	1 x 1000	20.00			
40.	Tablets Phenobarbitone (feroze sons) 30 mg.	1 X 1000	36.00			
41.	Tablets Grisoven 0.25 mg.	1 X 400	135.00			
42.	Tablets Dulcolax (Boehriger) 5 mg.	1 X 100	14.75			
43.	Syrup Sodium Acid Citrate 120 mg. (Local)	EACH	4.50			
44.	Tablets Nilstat Viginal (Lederle).	1 X 10	7.40			
45.	Lotion Gention Violet. 450 ml.	EACH	14.00			
	Lotion Gention Violet. 30 ml.	EACH	2.50			
46.	Tablets Methergin (Sandoz) 0.125 mg.	1 X 500	296.00			
47	Tablets Ferrous Sulphate (Glaxo).	1 X 100	4.25			
48.	Syrup Multivitimin 120 mg.	EACH	5.25			

THE SALVATION ARMY

Afghan Refugee Assistance Project

Medicine List.

S.NO	NAME OF MEDICINE	QUANTITY	MEDICINE CEN			
49.	Tablets Folic Acid (Nabi Qasim).	1 X 100	4.00			
50.	Tablets B Compound (Feroze Sons).	1 X 1000	20.00			
51.	Tablets Ostocalcium (Glaxo).	1 X 250	18.50			
52.	Drops Polivti (PDH).	EACH	4.80			
53.	Ointment Terramycin Eye (Iported).	EACH	2.25			
54.	Drops Otosorin Ear (Wellcome).	EACH	6.58			
55.	Chloramphenical Ear drops.	EACH	3.20			
56.	Chloramphenical Eye drops.	EACH	3.40			
57.	Hydrosol Salt (ORS).	EACH	1.55			
58.	Injection Ampicilline 250 mg. (Imported)	EACH	3.50			
59.	Injection Procain Penicillin (Pfizer)400000	EACH	2.55			
60.	Injection Hyoscine 5 ml.	1 X 30	70.00			
61.	Injection Avil (Hoechst) 2 ml.	EACH	1.10			
62.	Injection Aminophylline (China) 10 ml.	EACH	1.50			
63.	Injection Methergin (Sandoz) 1 ml.	1 X 50	97.75			
64.	Injection Lasix (Hoechst) 2 ml.	1 X 50	102.00			
65.	Injection Maxolon (Beecham) 2 ml.	EACH	6.16			
66.	Injection Diazepam (10 mg) 2 ml. (Imported)	EACH	1.10			
67.	Injection A.T.S (Pliva) 1500 iu.	EACH	4.00			
68.	Injection Adernaline (Marker) 1 ml.	1 X 100	68.00			
69.	Injection Decadorn (MSD) 4 mg. (2 ml).	1 X 25	143.00			
70.	Injection Sosegan (Winthrop) 1 ml.	EACH	11.60			
71.	Injection Xylocaine (Local) 2% 50 ml.	EACH	13.00			
72.	Injection Dextrose (China) 25% 20 ml.	EACH	1.50			
73.	Injection Dextrose Water (China) 5% 1000 ml	EACH	20.00			
74.	Injection Dextrose Saline (China) 1000 ml.	EACH	20.00			
75.	Methylated Spirit.	GALLON	60.00			
76.	Savalon Solution	1 LETER				
	Dettol.	50 ml.	5.25			
	Dettol.	1 GALLON	200.00			
77.	Syrup Calpol (Wellcome). 120 ml.	EACH	5.40			

THE SALVATION ARMY
Afghan Refugee Assistance Project

Medicine List.

S.NO	NAME OF MEDICINE	QUANTITY	MEDICINE CEN			
1.	Disposable Syringes (3 c.c.)	1 X 100	140.00			
2.	Disposable Syringes (5 c.c.)	1 X 100	135.00			
3.	Disposable Syringes (10 c.c.)	1 X 100	200.00			
4.	Cotton Wool.	200 mg.	8.00			
5.	Guaze Thans.	EACH	40.00			
6.	First aid plaster (Bandages).	1 X 100	22.00			
7.	Bandages (6").	DOZEN	8.00			
8.	Bandages (3").	DOZEN	4.50			
9.	Sticking Plaster (3").	EACH	20.00			
10.	Ethyl Chloride Spray.	EACH	34.00			
11.	Microscopic Slides.	EACH PKT.	25.00			
12.	Surgical Blades.	EACH	2.00			
13.	Stiching Material.					
14.	Distilled water for Injection.	1 X 100	50.00			
15.	Paracetamol Tab.	1 X 100	90.00			

ANNEX.13

THE SALVATION ARMY
Afghan Refugee Assistance Project

BALANCE SHEET

S.A.W.S.O. PD - 734 III
As at 30th September, 1990.

LIABILITIES	Rs.		ASSETS	Rs.	
Unspent Grant as at			***CURRENT ASSETS***		
30th September, 1990	325,741	49	L/W/Income Loan.	9,498	00
			Vocational Income Loan	26,502	00
			CASH & BANK BALANCES		
			Cash in Hand.	Nil	
			Cash at Bank.	289,741	49
TOTALS	325,741	49	TOTALS	325,741	49

PROJECT ACCOUNTANT

DIRECTOR

THE SALVATION ARMY
Afghan Refugee Assistance Project

INCOME AND EXPENDITURE ACCOUNT

S.A.W.S.O. PD - 734 III

For the year ended September 30, 1990.

EXPENDITURE			INCOME		
BUDGET LINE ITEMS	Rs.			Rs.	
Salaries.	1,963,722	00	Unspent Grant from 30th April,		
Staff Benefits.	107,267	29	1990. (PD - 734 II)	41,782	85
Professional Fee.	36,000	00	Grants received from SAWSO		
Travel Per Diem.	151,850	10	During the year.	4,641,494	88
Occupancy.	112,727	00			
Publication/Printing/Xeroxing.	4,830	00			
Telex / Telephone / Telegram.	38,375	90			
Postage / Shipping.	16,018	50			
Maintenance / Purchases /					
Rental of equipment.	214,193	00			
Supplies.	1,686,900	45			
Staff Training.	20,735	00			
Other.	4,917	00			
Unspent Grant as at 30th Sep.					
1990. transferred to Balance					
Sheet.	325,741	49			
TOTALS	4,683,277	73	TOTALS	4,683,277	73

PROJECT ACCOUNTANT

DIRECTOR

5. **FAMILY RECORD - MEDICAL**

The Project Management has also made a decision in this regard that all the medical records of the refugees being kept in the BHUs, which include the Family Book, Ante Natal cards and Under - 2 Road to Health charts will be given to the refugees prior to their departure to Afghanistan so that this could be used as reference by the health workers.

Another step taken in this regard is the issuance of birth certificates to the new born babies in the camps. These certificates will also help the health workers, besides finding out the exact date of birth , to evaluate the immunization status of the child.

PRIMARY HEALTH CARE SERVICES

The project management in preparation for future repatriation, evolved a strategy to train as many men and women as possible in primary health care, so that these trained personnel could be of help and assistance to their relatives and community.

In doing so, Canadian International Development Agency (CIDA) has funded the training of a total of 14 Community Health Supervisors (CHS) and 432 volunteer Community Health Workers (CHW), both at Ghazi and Haripur camps.

Each CHW is responsible for 30 families and similarly one CHS is responsible for 30 CHWs. The role of these health workers is to educate and create awareness among the refugee population about health prevention, and assist the BHU staff in locating different defaulters and in accomplishing the targets for immunizations, Ante Natal and Under-2 clinics.

Similarly on the same lines, again funded by CIDA the project commenced the training of Female Health Supervisors (FHS) and Female Health Workers (FHW) both at Ghazi and Haripur camps. The training at Ghazi has been completed and to date a total of 8 FHSs and 248 FHWs are working in the field. Whereas in Haripur camps the training is still continuing and it is hoped that by the end of April 1991 a total of 431 FHWs and 36 FHSs would be trained.

After the training is completed, the FHSs become part of the BHU staff and are paid members. Each FHS supervises a total of 12 FHWs who are volunteers, and each FHW is responsible for 12 ~ 15 families in respect of providing assistance at the time of need.

THE SALVATION ARMY
Afghan Refugee Assistance Project

INCOME AND EXPENDITURE ACCOUNT

S.A.W.S.O. PD - 734 II

For the year ended September 30, 1990.

EXPENDITURE			INCOME		
BUDGET LINE ITEMS	Rs.			Rs.	
Salaries.	2,827,962	00	Grants received from SAWSO		
Employee's Benefits.	156,991	41	during the year.	10,373,572	52
Professional Fees.	60,000	00			
Travel Per Diem.	243,543	79			
Occupancy.	1,002,416	40			
Publication/Printing/Xeroxing.	92,425	50			
Telex / Telegram / Telephone.	45,025	80			
Postage / Shipping.	19,714	50			
Maintenance / Purchases.	1,956,650	08			
Supplies.	3,192,018	20			
Staff Training.	63,318	00			
Other.	9,453	24			
Overspent Grant from 30th Sep.					
1989.	625,017	62			
Cash refunds Transferred to					
Social Services (General					
Donation A/C)	37,253	13			
Unspent Grant Transferred to					
PD - 734 III Project.	**41,782**	**85**			
TOTALS	10,373,572	52	TOTALS	10,373,572	52

PROJECT ACCOUNTANT **DIRECTOR**

MONTHLY ANALYSIS SHEET

PROJECT:- PD - 734 (III) Consolidated.

FOR THE MONTH OF: October, 1990.

CATEGORY	FUNDS SPENT TO 30/09/1990.	FUNDS SPENT CURRENT MONTH	FUNDS SPENT TO DATE	6/12 OF BUDGET	(OVER SPENT) OR UNDER SPENT	BUDGET BALANCE
SALARIES	1,963,722.00	349,740.00	2,313,462.00	2,604,410.63	290,948.63	2895359.25
STAFF BENEFITS	107,267.29	19,847.00	127,114.29	297,786.88	170,672.59	468459.46
PROFESSIONAL FEES	36,000.00	0.00	36,000.00	28,868.13	(7,131.87)	21736.25
TRAVEL / PER DIEM	151,850.10	26,103.00	177,953.10	296,936.88	118,983.78	415920.65
UTILITIES / OCCUPANCY	112,727.00	23,900.00	136,627.00	421,302.50	284,675.50	705978.00
PUBLICATION / PRINTING	4,830.00	158.00	4,988.00	64,727.50	59,739.50	124467.00
TELEX / TELEPHONE	38,375.90	2,098.00	40,473.90	67,830.00	27,356.10	95186.10
POSTAGE / FREIGHT	16,018.50	9,391.00	25,409.50	22,057.50	(3,352.00)	18705.50
MAINTENANCE / PURCHASES	214,193.00	12,808.00	227,001.00	369,750.00	142,749.00	512499.00
OFFICE/MEDICAL SUPPLIES	1,686,900.45	227,087.21	1,913,987.66	1,774,003.13	(139,984.53)	1634018.59
STAFF TRAINING	20,735.00	0.00	20,735.00	171,062.50	150,327.50	321390.00
OTHER / REPAIRING	4,917.00	0.00	4,917.00	12,750.00	7,833.00	20583.00
Totals	4,357,536.24	671,132.21	5,028,668.45	6,131,485.65	1,102,817.20	7234302.80

	DATE	TIME
SHEET PRODUCED ON :	30-Jan-91	10:39:25 AM

MONTHLY ANALYSIS SHEET

PROJECT:- PD - 734 (III) Ghazi.

FOR THE MONTH OF: October, 1990.

CATEGORY	FUNDS SPENT TO 30/09/1990.	FUNDS SPENT CURRENT MONTH	FUNDS SPENT TO DATE	6/12 OF BUDGET	(OVER SPENT) OR UNDER SPENT	BUDGET BALANCE
SALARIES	574,705.00	120,435.00	695,140.00	751,091.88	55,951.88	807043.75
STAFF BENEFITS	10,216.00	2,614.00	12,830.00	87,996.25	75,166.25	163162.50
PROFESSIONAL FEES	0.00	0.00	0.00	0.00	0.00	0.00
TRAVEL / PER DIEM	39,087.00	8,299.00	47,386.00	47,249.38	(136.62)	47112.75
UTILITIES / OCCUPANCY	29,849.00	1,825.00	31,674.00	92,533.13	60,859.13	153392.25
PUBLICATION / PRINTING	279.00	30.00	309.00	2,093.13	1,784.13	3877.25
TELEX / TELEPHONE	350.90	24.00	374.90	637.50	262.60	900.10
POSTAGE / FREIGHT	22.00	0.00	22.00	0.00	(22.00)	-22.00
MAINTENANCE / PURCHASES	19,843.00	1,935.00	21,778.00	87,146.25	65,368.25	152514.50
OFFICE/MEDICAL SUPPLIES	521,591.95	107,739.65	629,331.60	571,093.75	(58,237.85)	512855.90
STAFF TRAINING	0.00	0.00	0.00	0.00	0.00	0.00
OTHER / REPAIRING	0.00	0.00	0.00	0.00	0.00	0.00
Totals	1,195,943.85	242,901.65	1,438,845.50	1,639,841.27	200,995.77	1840837.00

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MONTHLY ANALYSIS SHEET

PROJECT:- PD - 734 (III) Haripur.

FOR THE MONTH OF: October, 1990.

CATEGORY	FUNDS SPENT TO 30/09/1990.	FUNDS SPENT CURRENT MONTH	FUNDS SPENT TO DATE	6/12 OF BUDGET	(OVER SPENT) OR UNDER SPENT	BUDGET BALANCE
SALARIES	949,013.00	172,680.00	1,121,693.00	1,188,905.63	67,212.63	1256118.25
STAFF BENEFITS	36,677.44	7,901.00	44,578.44	134,395.63	89,817.19	224212.81
PROFESSIONAL FEES	0.00	0.00	0.00	0.00	0.00	0.00
TRAVEL / PER DIEM	64,084.00	7,924.00	72,008.00	66,151.25	(5,856.75)	60294.50
UTILITIES / OCCUPANCY	41,039.00	6,246.00	47,285.00	123,568.75	76,283.75	199852.50
PUBLICATION / PRINTING	651.00	128.00	779.00	2,093.13	1,314.13	3407.25
TELEX / TELEPHONE	6,782.00	856.00	7,638.00	5,248.75	(2,389.25)	2859.50
POSTAGE / FREIGHT	0.00	0.00	0.00	318.75	318.75	637.50
MAINTENANCE / PURCHASES	73,655.00	6,092.00	79,747.00	109,979.38	30,232.38	140211.75
OFFICE/MEDICAL SUPPLIES	1,139,568.50	111,438.56	1,251,007.06	1,110,737.50	(140,269.56)	970467.94
STAFF TRAINING	0.00	0.00	0.00	0.00	0.00	0.00
OTHER / REPAIRING	0.00	0.00	0.00	0.00	0.00	0.00
Totals	2,311,469.94	313,265.56	2,624,735.50	2,741,398.77	116,663.27	2858062.00

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MONTHLY ANALYSIS SHEET

PROJECT:- PD - 734 (III) Peshawar.

FOR THE MONTH OF: October, 1990.

CATEGORY	FUNDS SPENT TO 30/09/1990.	FUNDS SPENT CURRENT MONTH	FUNDS SPENT TO DATE	6/12 OF BUDGET	(OVER SPENT) OR UNDER SPENT	BUDGET BALANCE
SALARIES	440,004.00	56,625.00	496,629.00	660,694.38	164,065.38	824759.75
STAFF BENEFITS	60,373.85	9,332.00	69,705.85	75,395.00	5,689.15	81084.15
PROFESSIONAL FEES	36,000.00	0.00	36,000.00	28,868.13	(7,131.87)	21736.25
TRAVEL / PER DIEM	48,679.10	9,880.00	58,559.10	157,505.00	98,945.90	256450.90
UTILITIES / OCCUPANCY	41,839.00	15,829.00	57,668.00	205,200.63	147,532.63	352733.25
PUBLICATION / PRINTING	3,900.00	0.00	3,900.00	60,010.00	56,110.00	116120.00
TELEX / TELEPHONE	31,243.00	1,218.00	32,461.00	57,746.88	25,285.88	83032.75
POSTAGE / FREIGHT	15,996.50	9,391.00	25,387.50	16,904.38	(8,483.12)	8421.25
MAINTENANCE / PURCHASES	120,695.00	4,781.00	125,476.00	170,531.25	45,055.25	215586.50
OFFICE/MEDICAL SUPPLIES	25,740.00	7,909.00	33,649.00	90,078.75	56,429.75	146508.50
STAFF TRAINING	20,735.00	0.00	20,735.00	171,062.50	150,327.50	321390.00
OTHER / REPAIRING	4,917.00	0.00	4,917.00	12,750.00	7,833.00	20583.00
Totals	850,122.45	114,965.00	965,087.45	1,706,746.90	741,659.45	2448406.30

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M O N T H L Y   A N A L Y S I S   S H E E T

PROJECT:- PD - 734 (III) T.H.Q.   FOR THE MONTH OF: October, 1990.

CATEGORY	FUNDS SPENT TO 30/09/1990.	FUNDS SPENT CURRENT MONTH	FUNDS SPENT TO DATE	6 / 12 OF BUDGET	(OVER SPENT) OR UNDER SPENT	BUDGET BALANCE
SALARIES			0.00	3,718.75	3,718.75	7437.50
STAFF BENEFITS			0.00	0.00	0.00	0.00
PROFESSIONAL FEES			0.00	0.00	0.00	0.00
TRAVEL / PER DIEM			0.00	26,031.25	26,031.25	52062.50
UTILITIES / OCCUPANCY			0.00	0.00	0.00	0.00
PUBLICATION / PRINTING			0.00	531.25	531.25	1062.50
TELEX / TELEPHONE			0.00	4,196.88	4,196.88	8393.75
POSTAGE / FREIGHT			0.00	4,834.38	4,834.38	9668.75
MAINTENANCE / PURCHASES			0.00	2,093.13	2,093.13	4186.25
OFFICE/MEDICAL SUPPLIES			0.00	2,093.13	2,093.13	4186.25
STAFF TRAINING			0.00	0.00	0.00	0.00
OTHER / REPAIRING			0.00	0.00	0.00	0.00
Totals	0.00	0.00	0.00	43,498.77	43,498.77	86997.50

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The women and young children (under the age of 5) constitute 44% of the total refugee population and are most vulnerable group of the refugee population. Their health is always at risk because of multiple pregnancy, lack of knowledge about Ante-Natal and Post-Natal care, nutrition, care of the new born baby, personal hygiene and prevention of some common diseases.

Keeping in mind the above facts, now the project is placing more emphasis on the prevention of diseases rather than curing them.

Further services being provided are as follows:

1. **ANTE NATAL CLINIC**

According to the WHO / UNICEF / UNESCO book "Facts for Life", every year half a million women worldwide die from problems linked to pregnancy and childbirth, leaving behind over one million motherless children.

The Maternal Mortality Rate (MMR) and the Infant Mortality Rate (IMR) among the Afghan refugee population are among the highest in the world.

The above clinics were commenced with the aim of decreasing the MMR and IMR in the camps where the Army is working.They are conducted by Lady Health Visitors (LHVs), once a week in each BHU for the pregnant women who are usually in their second trimester. The women coming for the first time are registered in the BHU and an ante-natal card is completed stating all the relevant information and during the reporting period 1187 new cases were registered in the Ante Natal clinics for future care. 96% of the total registered women in these clinics were attending on a regular basis.

Tetanus Toxide (TT) injections are given to the women who have not previously been immunized or had incomplete immunization status. A total of 4777 women received their TT injections through these clinics.

The women attending the Ante-Natal clinics receive education about ante-natal care, importance of immunizations during pregnancy, nutrition, post-natal care, care of the new born baby and breast feeding etc.

The expectant mothers are encouraged to contact the BHU staff, Traditional Birth Attendants (TBAs), the Female Health Supervisor's (FHSs) or the Female Health Worker's (FHWs) who will assist them at the time of delivery.

During the current reporting period out of the total of 971 births recorded, 607 or 63% of the deliveries were assisted by the above mentioned staff.

Efforts are made by the all the concerned staff to encourage the pregnant women to contact the BHU staff at the time of delivery, a scheme of giving birth certificates has also been introduced in the camps. These birth certificates can play an important role after refugees repatriation as it will give accurate age of the child and his / her immunization status to any health worker.

2. UNDER TWO'S CLINIC

It is evident from the name that this clinic is held for the children who are under the age of two and are more susceptible to diseases than the older children because of unhygenic living and severe weather conditions.

The objective of the under-2 clinic is to help every child achieve its maximum potential of mental and physical development and the main aim of this clinic is to provide low cost curative and preventive care to meet the pediatric challenges focusing on the following four essential components of treatment, immunization, growth monitoring and health education.

This clinic is also held once a week in each BHU, all the children attending are weighed and registered in the clinic, special attention is given to those who are malnourished or undernourished due to varying reasons. At the end of the current reporting period a total of 1183 new cases were registered in the Under-2 clinic and the visit per child to the Under-2 clinic recorded was 2.47 times.

Out of the total of 2461 registered under-2 children, 647 are underweight, of these 340 are in the 1st degree, 206 in the 2nd degree and 101 are in the 3rd degree. Similarly 192 children showed improvement in their weight.

The immunization status of every child is checked and if found incomplete, they are referred to the vaccinators for immunizations. This is also recorded in the growth chart of every child and the mothers are also educated about the importance of immunizations. A total of 6501 under-2 children attendances were recorded by the vaccinators.



The mothers are advised regarding weaning food and preparation of different food items. In most of the cases the LHVs practically demonstrate and prepare different food items in the presence of mothers and the prepared food is given to all attending children to eat. Doing this way, the mothers are encouraged to feed their children the same way in their homes.

The mothers are also educated about breast feeding and its importance because bottle feeding, especially in the poor communities, is a serious threat to the lives and health of the children.

The mothers are also informed about the control of diarrhoea through O.R.S. and its preparation at home. Diarrhoea causes dehydration, which kills approximately 3.5 million children worldwide every year. Diarrhoea is also a major cause of child malnutrition. The main causes of diarrhoea are poor hygiene and lack of clean drinking water.

3. EXPANDED PROGRAM ON IMMUNIZATION (E.P.I)

This is one of the most important aspects of the preventive health services and is receiving much importance because of its value and effect on future generations. Immunization protects against six dangerous diseases. A child who is not immunized is more likely to become under-nourished, disabled and to die.

Facts for Life shows that worldwide, without immunization, an average of three out of every hundred children born will die from measles, another two will die from whooping cough, one more will die from tetanus, and out of every two hundred children born, one will be disabled for life by polio.

In order to fully immunize the refugee population, one vaccinator is stationed at each BHU where he works for three days in co - ordination with female staff of the BHUs and for the other three days he goes into the camps for out reach activities. He travels to every part of the camp and locates and immunises the defaulter's as well as registering and immunizing new cases, with the help of CHSs and CHWs.

Out of the total under-2 population, 6501 children were immunized and of these 1450 or 22% children were fully immunized. Similarly, out of the total of 4777 recorded attendances of Child Bearing Age women by the vaccinators, a total of 1443 or 30% were fully immunized during the reporting period.



The defaulter's are also located and motivated by the personnel of the outreach team, who are provided with the details by the vaccinators who keep a complete record of all the immunizations and the status of child.

Now with the new change brought about in the E.P.I programme by the W.H.O. and the Project Director Health for Afghan Refugees, children under the age of two have been made the primary target for immunizations. Similarly, all the women in Child Bearing Age (CBA) have been made the primary target for Tetanus Toxide injections.

One of the most important aspects in connection with preparing the refugees for repatriation is to completely immunize the whole population. The Salvation Army has undertaken this responsibility and is striving hard to immunize as many under-2 children and CBA women as possible. In order to achieve this goal all the available resources are being utilized.

4. **HEALTH EDUCATION**

Health education is yet another factor which plays a very important role in improving the health of the community, because more than half of all illnesses and deaths among the young children is caused by germs which get into the child's mouth via food and water mainly because of lack of knowledge about personal hygiene.

In poor communities without latrines, without safe drinking water and without safe refuse disposal, it is very difficult for families to prevent the spread of germs. It is therefore vital for the people to be aware of different prevalent health problems and their prevention.

In order to further enhance the message of health education and create awareness among the people in the camps as much as possible, the project management decided to built a separate room in each BHU, particularly for imparting health education. Known as the "Health Education Room", health education is given by the BHU staff to all the patients attending the BHUs for their illnesses, in small groups of 10 people. During the concluded period a total of 76,329 patients attending the BHU received health education.

This health education has been made compulsory and no patient is examined by the doctor unless he has been to the Health Education Room and received some teaching.



Health Education is also being given in the camps to both men and women by different outreach workers. A total of 35023 men and 17617 women received health education on a variety of topics which cover personal and environmental hygiene, prevention of communicable diseases, importance of immunizations, clean drinking water, control of diarrhoea diseases, prevention of Malaria and T.B, importance of O.R.S and its preparation etc.

Similarly the outreach workers visit the boys and girls schools in the camps and impart health education on personal hygiene, prevention from communicable diseases, importance of immunization, prevention from diarrhoea and use of clean water and food.

During the reporting period the outreach health workers contacted 20,552 boys and girls for health education.

5. HOME VISITS

The female health workers and the BHU staff (Female) contact the female refugee population through regular home visits and besides imparting health education also follow up un-registered Ante Natal, Post Natal and Malnourished under-2 children in general and the registered in particular.

A total of 1929 Ante Natal and 1798 Post Natal cases were contacted in order to ensure the correct ante and post natal care of the women, care of the new born baby, breast feeding and weaning food practices.

6. GENERAL O.P.D. CLINICS

Both curative and preventive health are part of any primary health care programme especially among the refugee community with whom we work. This community has some very urgent curative health needs like T.B, Malaria, skin infections and upper respiratory infections etc. That is why some sort of balance has to be kept between the preventive and curative programmes in order to care for the refugees physically and mentally.

The project through its general O.P.D. clinics for male and female, 6 days a week is responding to the urgent medical needs of the people. Each general O.P.D. is conducted by a male and female medical officer, in each BHU on alternate days. The patients are examined by the medical officer and are prescribed medicines.

During the current period, The Salvation Army has established an indigenous Afghan N.G.O. named Afghan Development Agency (A.D.A.) which will be able to receive funding for cross-border work and prepare the ground for the repatriation of refugees by reconstructing the rural and economic life of villages in Afghanistan.

It is hoped that A.D.A. will soon become active in Afghanistan by commencing some small scale projects and later moving into larger projects.

Enclosed in Annex 11 is the document "A History of The Development of an Afghan Non-Governmental Organisation (NGO) - The Salvation Army Story" which details the work done to create this Afghan NGO.



INTRODUCTION AND BACKGROUND

Today, Pakistan is catering for the needs and welfare of about 3.2 million Afghan Refugees, which constitute the single largest refugee population in the world.

These refugees are residing in 384 camps in 17 districts and tribal agencies of Pakistan. Most of these refugees live in the North West Frontier (75%), Baluchistan (20%), and Punjab (4%) provinces. The remainder are scattered elsewhere in the country.

The majority of the refugees are pathan tribesmen, primarily from Afghanistan's eastern regions, a small number are Baluchi's, Hazara's, Nuristani's and Turkmen.

Out of the total refugee population residing in Pakistan, 51% of them are children, 26% are women and 22% are men.

The Salvation Army commenced its operation by setting up two Basic Health Units (BHUs) in Ghazi camps in August 1982. Since then, The Salvation Army has been providing Medical Services, and later also Female Community Health Education, Vocational Training and Income Generating activities to an estimated 80,000 refugees residing in seven tentive villages in the Hazara Division of the N.W.F.P.

The funding for the Medical Programme is being provided by the U.S. State Department Bureau for Refugee programmes, for Female Community Health Education programme by Canadian International Development Agency (CIDA), for Vocational Training and Income Generation jointly by Inter Church Co - ordination Committee for Development Projects (ICCO) of The Netherlands and European Community (EC) and for Food Preservation programme by STICHTING VLEUTCHELING of Netherlands.

The Salvation Army is working at two locations in the N.W.F.P., Ghazi and Haripur, approximately 120 and 160 k.ms east of Peshawar.

For the current project period, a proposal for the grant of U.S. $631,819.00, was submitted to U.S. State Department through SAWSO in February 1990 for the basic Medical and Administration programmes. This was kindly accepted and approved by the U.S. State Department.



MANAGEMENT AND ADMINISTRATION

The Salvation Army, Afghan Refugee Assistance Project, through its main office based at Peshawar, is responsible for the overall activities in the field.

The Territorial Commander at The Salvation Army, Territorial Headquarters at Lahore is the official representative of the Army's refugee project.

The Director at Peshawar Field Office, who is a Salvation Army officer, reports to the Territorial Commander.

At field level, each component of the project is being supervised and implemented by a programme officer who is responsible to the Director. All these programme officers are assisted by administrative staff.

The Project Accountant, Manager Administration and their ancillary staff are based in Peshawar office providing financial and administrative support to their colleagues in the field. They both report directly to the Director.

The field offices at Haripur and Ghazi are responsible for daily work and support to the staff working in the camps. These offices send monthly progress reports on their activities, to Peshawar office.

The Peshawar office, besides providing financial and administrative support to the field offices, is responsible for preparing monthly financial reports and periodical progress and narrative reports on the programmes as per donor requirements.

THE SALVATION ARMY

Afghan Refugee Assistance Project
PAKISTAN



FIRST INTERIM REPORT

PROJECT PD - 734 (III)

PERIOD 1ST MAY 1990 - 31ST OCTOBER 1990

MEDICAL PROGRAMME

Peshawar

January 1991



THE SALVATION ARMY

Afghan Refugee Assistance Project

PAKISTAN

LIST OF CONTENTS

LIST OF ANNEXES



ACKNOWLEDGMENT

The Project management extends its' sincere thanks to the U.S. State Department Bureau for Refugee Programs for their continued funding support to this project over the last eight years. This support has enabled the project to provide continuous assistance to a total of 80,000 Afghan Refugees residing in Haripur and Ghazi refugee camps. Without U.S. State Department's assistance and funding, the project would not have existed.

It is important to note that including this grant, this is the ninth consecutive grant from the Bureau for Refugee Programmes of the U.S. State Department, through The Salvation Army World Service office (SAWSO) in Washington D.C.

The management also thank the staff members at The Salvation Army World Service Office (SAWSO), Washington, who have not only helped in securing funding to continue our activities among the refugees by representing this project in the best possible way at Capitol Hill, but also provided technical assistance and advice in order to improve the quality of the services being provided by the project.

We would also like to register our thanks to The Salvation Army International Headquarters Development Services department for their untiring efforts to publicise the project's work and to raise funds for the project in particular and the refugees in general.

We would also like to register our sincere thanks to Colonel John Nelson, Territorial Commander and his staff at The Salvation Army Territorial Headquarters Lahore, for their support and advice which has helped in the smooth running of the project.

Finally, we would like to thank the Project Administration staff namely, Captain and Mrs.Ivor S.Telfer, Director and Advisor, Primary Health Care, Dr.Abdul Wahab, Program Officer Medical Services Haripur, Dr.Zainul Abedin, Programme Officer Medical Services Ghazi, Mr.Syed Mehmood Asghar, Manager Administration and Mr.Abid Shehzad, Project Accountant who all have made every effort in their respective fields to make this project a real success.

Last but not least, finally we would sincerely like to thank the most important part and the strength of our project, our staff, who have contributed tremendously in achieving the project goals and objectives. It was due to their dedication and willingness to work that, although often faced with many constraints in the field, they have always managed to perform their duties to a high standard.



In conclusion, we would like to thank all those who were involved in the preparation of this report and all those who have contributed by offering their comments and advice in the formulation of this report. The Management look forward to receiving valued comments from the readers this report.

PESHAWAR
17TH DECEMBER 1990



SECTION I

PREFACE

It is with pleasure that we introduce to our readers the First Interim Report on our Medical and Administration programmes for PD-734 (III) covering the period from 1st May 1990 to 30th October 1990.

As mentioned earlier, this programme has been funded by the U.S. State Department, Bureau for Refugee Programmes through The Salvation Army World Service Office in Washington D.C.

This report deals in detail with all the achievements accomplished during the reporting period and also the of The Salvation Army regarding the future of refugees in Pakistan as well as in Afghanistan.

As mentioned in our previous report dated June 1990, the conflict in Afghanistan is still unresolved and Pakistan is still hosting 3.2 million refugees and is faced with further cuts in the basic ration supply to the refugees.

The reason for the cut in rations seems to be due to the fact that concerned U.N. and donor countries have not been able to provide funds or food assistance required to cater for the needs of these refugees.

According to ACBAR, UNHCR and Press sources in Peshawar, UNHCR's budget for 1991 has been reduced by 20%, from U.S. $ 40.4 million to U.S. $ 32.4 million. The reason for this reduction is said to be the global reduction of donations for the refugees.

There is a concern among the refugees that the reduction in assistance could be used as a weapon to encourage them to return to Afghanistan. The reduction in donations means reduction in assistance or food rations which at this stage are not enough for one person - according to World Food Programme standards - and a further cut in the rations will definitely effect refugees who have no other means of support.

Similarly, the Government of Pakistan's Afghan Refugee Commissionerate through which all the refugee camps are being administered is planning to release about 2000 workers, also due to lack of funds.



Also mentioned in our last report was the Agency Co-ordinating Body for Afghan Relief's (ACBAR) team visit to 13 countries to redress the reduction in aid and to stress the importance of continuation of programmes in Afghanistan together with assistance to a larger number of refugees in Pakistan. This visit failed to bear any notable results on the funding situation.

The ACBAR in its efforts to pursue donors for funding arranged a tripartite conference of UN agencies, Donors and NGO representatives in Islamabad to discuss the possibilities of future funding for Refugee programmes as well as for Programmes in Afghanistan.

Funding problems did affect The Salvation Army's vocational training and income generation project for most of 1990 but now due to timely acceptance of funding proposals by Inter Church Co-ordination Committee for Development Projects (ICCO) of the Netherlands and the European Community (EC), this project is now able to continue.

The Salvation Army extends its sincere thanks to both ICCO and the EEC for taking up funding of our vocational training and income generation projects.

Although The Salvation Army Afghan Refugee Assistance Project now is not facing funding problems, the overall aid to the Afghan people has decreased. At the recent ACBAR/DONOR/UN conference mentioned above, most bilateral donors advised of no reduction in funding during 1991/92. However, due to extra funds given by the bilaterals to UNOCA as well as the annual contribution in 1989/90, these extra funds will not be forthcoming in 1991, hence an actual overall reduction in funding for the Afghan people.

Further, the UNHCR has a shortage of funding, thus affecting the refugee situation. Some donors also will not give any more funds until a repatriation has commenced.

The UNHCR has initiated a programme of repatriation of refugees in May 1990, providing Rs.3,300.00 to each returnee, on surrendering his ration pass book, along with a package of food and some agricultural instruments. According to UNHCR report only 8259 families responded to this offer due to pressure from some political groups and also the unstable situation in parts of Afghanistan. A further deterrent to repatriation is a large number of uncharted mines and other unexploded ordinances.